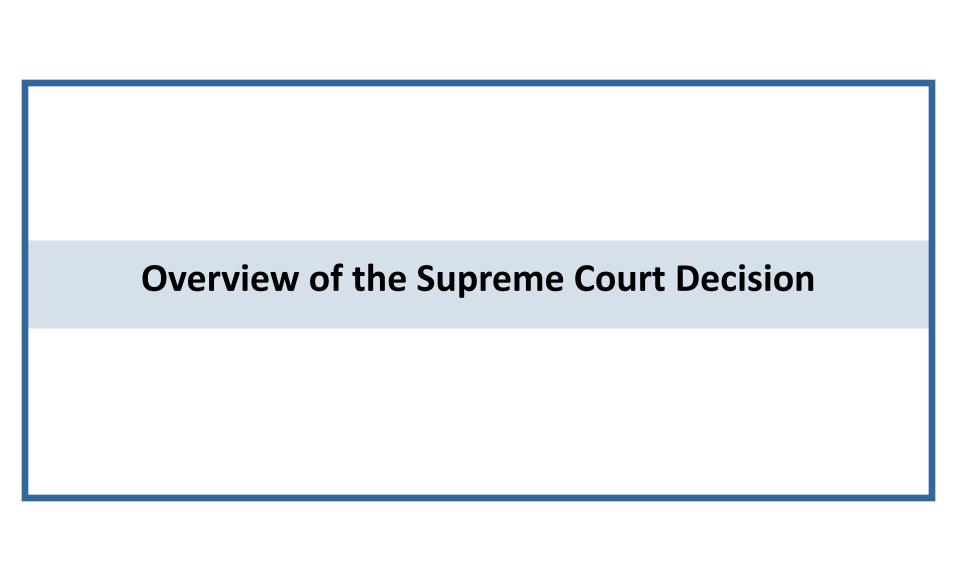
Evaluating Medicaid's Options & Obligations After the Supreme Court's ACA Decision

Washington Health Care Authority
August 8, 2012



Overview of the Decision

A divided Supreme Court ruled that:

The Affordable Care Act (ACA)
 requirement for individuals to have
 insurance or pay a tax penalty is
 constitutional.

 States can choose not to expand Medicaid to cover all state residents under 138% FPL, without risking federal funding for their entire Medicaid program. "The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."

- Chief Justice Roberts in Majority Opinion

"In this case, the financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'—it is a gun to the head."

- Chief Justice Roberts in Majority Opinion

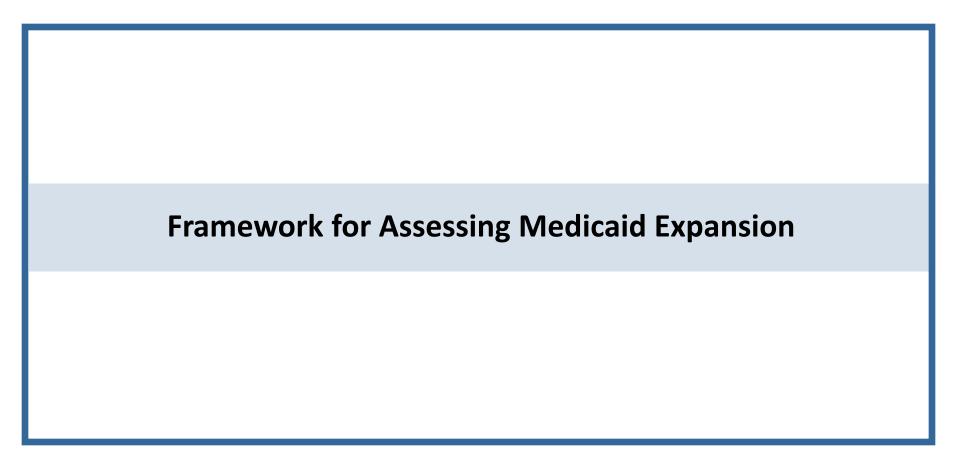
The Decision's Implications for Medicaid

States May Opt Out of Medicaid Expansion

The Balance of ACA Medicaid Provisions Stand

- Simplification and Streamlining
- Children's Expansion
- Maintenance of Effort
- Drug Rebates in Medicaid Managed Care
- DSH Payment Reductions
- Delivery System Reform

Welcome Mat Effect Occurs Regardless of Expansion



Medicaid Expansion: Factors for State Evaluation

Cost of coverage for adults in new expansion group

State savings from current Medicaid and state funded populations and programs and new state revenue

Broader economic value of additional health care dollars to health care system and state economy

1

Estimate Cost of Coverage for Newly Eligible Adults

- Define: Adults under age 65 with incomes below 138% FPL who are not eligible under an existing Medicaid category
- Numbers: Calculate number of uninsured adults in state who fall into this new adult group
- Enrollment: Project take-up rates; no means-tested program ever achieves 100% take-up
- Cost of Coverage: Multiply projected enrollment by PMPM cost
- Federal/State Cost Breakdown: Calculate state share of costs; enhanced federal fund cover 100% costs of "newly eligible" adults from 2014 through 2016, leveling off at 90% in 2020
- National estimates of cost of "newly eligible" adults (2014-2019):
 - Federal spending: \$427.2 billion
 - State spending: \$17.1 billion



2

Offset State Savings and New State Revenue

- Current Medicaid Populations that Can Move to New Adult Group with Enhanced Federal
 Matching Dollars or to Exchange with Tax Credits
 - Coverage through 1115 waivers
 - Breast and Cervical Cancer Treatment Program
 - SSI Presumptive
 - Other?
- Current State-Funded Programs for Uninsured Individuals
 - Uncompensated care pools
 - Public and private mental health/substance abuse programs and agencies
 - State high risk pools and other private market supports
 - Health care costs of prisoners
 - Other?
- Current Locally-Funded Programs
- Additional Revenue From Provider/Insurer Assessments and Business Taxes

3

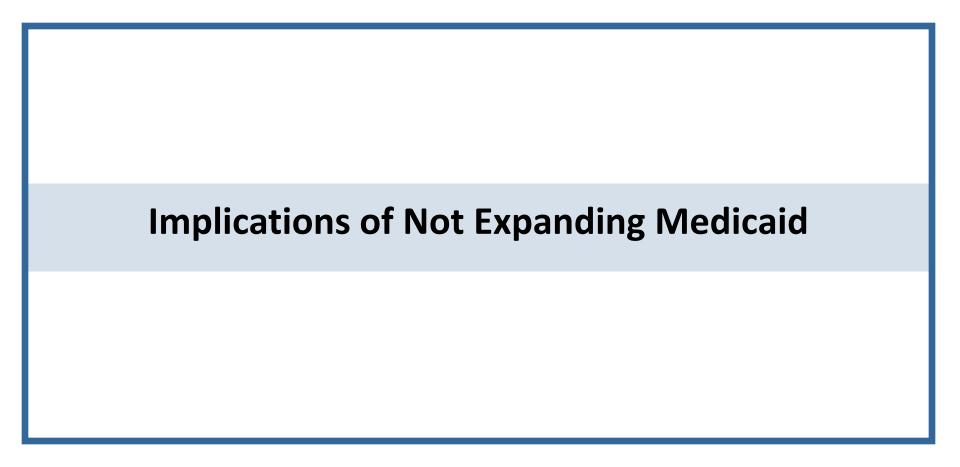
Project Impact on State Economy

Reduced Numbers of Uninsured

- Improved access to care and reduced mortality
- Reduces personal bankruptcy; medical debt is leading cause
- Less cost-shifting by providers
- Facilitates reform of health care delivery system

Increased Revenue for Providers

- Especially critical for hospitals to offset reductions in DSH and Medicare rates
- Increased Employment in Health Care Sector



Implications of Not Expanding Medicaid: Consumers

- Individuals eligible for Premium Tax Credits only if their income is above 100% of the FPL; no subsidies available for:
 - Childless adults with incomes below 100% of the FPL
 - Parents with incomes between 74% (MAGI-converted) and 100% of the FPL
- Patchwork of coverage continues
- Continuity of coverage and care compromised
 - Individuals will not experience seamless transitions between Medicaid and Premium Tax Credits in the Exchange
 - Churning becomes a bigger problem

Implications of Not Expanding Medicaid: Providers

- Hospitals will see reductions in federal DSH funding
 - Preliminary total Medicaid State DHS allotment in 2011 = \$11.3 billion
 - Reduction to total State Medicaid DSH allotments start in 2014:
 - 2014 \$500 million
 - 2015 \$600 million
 - 2016 \$600 million
 - 2017 \$1.8 billion
 - 2018 \$5 billion
 - 2019 \$5.6 billion
 - 2020 \$4 billion
 - If Washington does not choose to expand Medicaid, hospitals will face both DSH cuts and continuing uncompensated care burden
- With expansion, hospitals in Washington will see uncompensated care cost reductions estimated to be between \$477 million and \$608 million

Implications of Not Expanding Medicaid: Employers

- Employers will have new coverage obligations with respect to individuals with incomes between 100% and 138% FPL
- Large employers (50+) will face a penalty if one or more of their full-time employees with incomes between 100% and 138% FPL obtain a premium tax credit through the Exchange
- Penalty assessed on a monthly basis and calculated based on the number of full-time employees and whether the employer offers affordable
 Minimum Essential Coverage

Implications of Not Expanding Medicaid: Exchange

- Complex administration of the interface between State Medicaid programs and Exchange
 - Higher volume of "hand-offs" from Exchange to the State
 Medicaid agency, as a result of very low-income people seeking
 full Medicaid determinations and/or authorization to "spenddown" to the State's Medicaid eligibility level
- Instead of a uniform eligibility threshold for Medicaid at 138% of FPL, Medicaid programs and Exchanges will be determining eligibility against patchwork of existing state Medicaid categories of eligibility with variable income levels

Open Policy Questions

Question: Is the adult expansion an "all or nothing" choice? Will states be allowed to expand adult coverage to levels less than 138% and receive the enhanced match?

Answer: Unclear

Question: Will states be able to opt in and out of the adult coverage option over time?

Answer: Yes

Question: Must a state expand its Medicaid program by January 1, 2014? May a state phase in Medicaid coverage up to 138% FPL (or less) after January 1, 2014 and still receive the enhanced FMAP?

Answer: Per the ACA, expansion to 138% of the FPL is effective January 1, 2014. No matter when a state begins expansion, the 100% matching rate ends in 2016.

Question: Do all other Medicaid provisions stand?

Answer: Yes (see discussion that follows)

Balance of Medicaid-Related ACA Provisions Stand

Simplification and Streamlining	 Simple, seamless system to determine eligibility for Medicaid, CHIP and Premium Tax Credits (PTCs); integrated with Exchange 90/10 funding for development of ACA-compliant Medicaid eligibility systems and 75% match for operations; spillover benefit for social services programs.
	 Standardized definition of income (MAGI) to determine program eligibility for Medicaid/CHIP/PTCs.
Children's Expansion	 Increases Medicaid eligibility to 138% FPL from 100% FPL for children ages 6 to 18
Maintenance of Effort	 Requirement to maintain current eligibility levels/procedures for Medicaid & CHIP until 2014 for most adults and 2019 for children Adult MOE ends when Secretary certifies Exchange operational in a state State receives enhanced match for CHIP (23 percentage points) starting in 2015

Balance of Medicaid-Related ACA Provisions Stand

Drug Rebates in Medicaid Managed Care	 Authorizes states to access prescription drug rebates for enrollees of Medicaid managed care plans
DSH Payment Reductions	 Secretary to determine reduction methodology ACA requires largest reduction to states with lowest percentage of uninsured; or, do not target to hospitals with high-Medicaid volume and high uncompensated care costs ACA also requires smaller reductions to low-DSH states
Delivery System Reform	 Health home services for chronically ill Medicaid patients funded 90% federally for 2 years Medicaid primary care payment increases to parity with Medicare rates in 2013 and 2014, funded 100% federally Medicaid and Medicare innovation initiatives, including Accountable Care Organizations and Dual Eligible Initiatives

Questions?

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